ART OF THE HEART
COUNSELING SERVICES LLC

INFORMED CONSENT, OFFICE POLIES, AND TREATMENT AGREEMENT

Art of the Heart Counseling Services LLC (AHCS) welcomes you to our practice! Please take the time to read our general information packet and sign when complete. We know it's a lot, but it's important to get a good understanding of what to expect. Please contact Marissa Zemaitis, LPC at (203)200-7055 for questions/concerns.

CONFIDENTIALITY

The therapeutic relationship is a privileged relationship and the content of all discussions, assessments, noted, and evaluations are protected. This information can only be released by your consent. Client information may be discussed with colleagues, staff members, and/or supervisors without using identifying information for the purposes of case management, administrative work, treatment plan development, or any other related matters.

Privacy for Teens/Children: Since openness and trust are essential to effective therapy, it is important that a teen or child feels that they have privacy to discuss all the issues that are troubling them. While parents have a right to know about their child's progress in therapy, I will limit disclosures to parents to what I feel is in the child's best interest, what the child has given me permission to share, or when there are safety issues. Since the goal is to build trust and minimize secrets, client will be made aware of any communications with family members.

Exceptions to Confidentiality based on the professional standard and Connecticut law include:

1. When physical harm is threatened against another person,
2. When physical harm is threatened against oneself,
3. When physical abuse or neglect is directed at a child or adult,
4. When records are subpoenaed by state or federal court.

FEE POLICIES

AHCS's standard counseling fee for the most used psychotherapy services are as follows:

- Individual Psychotherapy Sessions (Children, Teens, and Adults)
  - 30 minutes - $130 45 minutes - $150 60 minutes - $165
- Couples or Family Psychotherapy
  - 50 minutes - $150
- Psychiatric Diagnostic Evaluation (Clinical Intake or Assessment)
  - 90 minutes - $200
- Group Therapy - $50 per session

If you have insurance where we are part of the network, your insurance may pay for all or a portion of the counseling fee.

An optional sliding scale is available, based on monthly income and expenses detailed on the Out-of-Pocket Form. Declining to complete the Out-of-Pocket Form will result in the application of the standard counseling fee by default. Payment for counseling services is your responsibility and due at the time of your counseling appointment. If full payment is not rendered at the time of the appointment, a late fee may be added. Failure to pay will result in an invoice being sent. Subsequent failure to pay the amount due in the allotted time frame may result in the invoice being sent to collections.

CANCELLATIONS

Sessions are by appointment only. While we hate charging for missed sessions, that time was reserved for you. Therefore, you will be charged a cancellation or no-show fee or $20 for missed sessions or for those cancelled without 24-hour notice, except in medical or other emergency situations. Insurance will not pay for missed sessions. Since your time if also valuable, if I forget a session or if we make a scheduling error, you get one session for free.

INSURANCE

Although we make every effort to check in with your insurance for coverage prior to your first session, we suggest that you also check in with your provider to determine your coverage. You can visit our website at www.artoftheheartcounseling.com. The page titled "Rates and Insurance" gives pointers on what to ask your insurance company when you call.

If we are a provider with your plan: We will submit claims for you; however, during our session, you must pay any co-pay or any portion not covered by your plan. There may be a deductible (any amount you need to pay out of pocket) before your plan begins covering any sessions. If insurance does not pay as expected, you remain responsible for the balance. You have the right to waive insurance coverage, if desired.

If we are NOT a provider for your plan: Full payment is due at the time of session. We can provide you with an invoice if you wish to seek reimbursement from your plan. Many plans do not cover sessions with a provider who is out of their network.

Diagnostic Labeling: Insurance companies require a diagnosis to pay for mental health services. A diagnosis will be developed based on the information provided during the Clinical Intake and will be continually assessed throughout your care. This diagnosis will become a part of your insurance file. If you prefer not to have a diagnosis, you may use Private Pay based on the standard counseling fee.

THE THERAPEUTIC PROCESS AND SCOPE OF PRACTICE

Participation in therapy can be beneficial, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort, active involvement, honesty, and openness on your part for it to be effective. Your therapist will ask for your feedback on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly.

During evaluation or therapy, we may have to discuss stressful events, feelings, or thoughts that might bring up difficult responses for some. Your therapist will use different verbal and nonverbal therapeutic modalities to help you resolve issues that brought you to therapy in the first place. The length of treatment is dependent on your progress, for example, when the problem or issues have lessened to the point that you no longer need therapy services. Treatment length is not started but may be mandated by insurance reimbursement. There are no known or inherent risks to participating in art therapy or counseling. Generally, it is expected that through the accessing and processing of emotions, client will feel an improvement in their overall well-being; however, such results are not guaranteed.

During the course of therapy, your therapist will likely draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, psychodynamic, existential, system/family,

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developmental (adult, child, family), humanistic or psycho-educational, art therapy, or group therapy. AHCS providers do not provide custody evaluation recommendation, medication or prescription recommendation, or legal advice, as these activities do not fall within our practice. AHCS is not responsible for the behavior, actions, etc. of clients (current and past), or any persons associated with those clients.

Therapists' Background: You can access your therapist's professional background on our website, www.artoftheheartcounseling.com.

Availability: AHCS does not provide 24-hour availability. For emergencies, contact 911 or 211 for assistance, or go to the nearest emergency room.

Alternatives to Therapy: You are voluntarily entering into a therapeutic relationship with AHCS. There are alternatives to entering therapy. You can discuss this with your clinician should you decide you no longer wish to participate in therapy.

Audio or Video Recording: Unless otherwise agreed to by parties beforehand, there shall be no audio or video recording or therapy sessions, phone calls, or any other services provided by AHCS.

Referrals: A referral to another provider may become necessary if it becomes clear in our opinion that your issues would be better treated by a professional with different expertise. It is unethical for us to practice beyond the level of our competence, education, training, or experience. We are not responsible for the care received from professionals to whom we refer you.

Endings: If you are unhappy with any aspect of therapy, please don't just leave. We ask that you talk to your therapist to see if the concerns can be worked out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and we are happy to assist with referrals. It is our ethical duty to provide therapy only when we feel you are actively participating and benefiting from the sessions. We may end treatment if there have been repeated no-shows, late cancellations, or other treatment interruptions.

CLIENT/PATIENT RIGHTS

You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender/gender identity, age, mental or physical disability, medical condition, sexual orientation, medical history, evidence of insurability, or source of payment.

PHONE/TEXT/EMAIL/SOCIAL MEDIA

Phone, text, and/or email may occur for both scheduling and communication purposes. Although devices containing identifying information are kept password protected, this information may be accessible to third parties. AHCS does not offer therapy by email or text. However, we do offer telehealth (phone or video) on an encrypted platform. By signing this form, you agree to email, text, and phone communication unless otherwise indicated by you directly to your therapist. We do not accept friend requests or contact request from clients on social networking sites out of concern for your confidentiality and our privacy.

LEGAL MATTERS

AHCS does not provide any legal advice as it is out of our scope of practice. We do not participate in any legal

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proceedings such as court appearances or depositions as the time spent in court-related matters can be extensive and may result in lost opportunities for needed care for other clients and lost income for the sessions the therapist must miss. If court-related letters/correspondence are requested, we may be able to provide this service (on a case-by-case basis) for a fee of $95/hour for any time the therapist must spend of your case.

PRIVACY PRACTICES

By signing this form, I agree that I have seen and/or received the Notice of Privacy Practices. The Notice of Privacy Practices provides information on how AHCS may use and disclose your private health information. I understand that I may receive a copy at any time per request.

EMERGENCIES

If there is an emergency during therapy, or in the future after termination, where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the person whose name you have provided on the biographical sheet.

CONSENT TO TREATMENT

The therapeutic relationship you are entering is governed by the policies contained within this Informed consent and contract, as well as in the Notice of Privacy Practices. These policies are not assumed to be all inclusive nor do they preempt any state, federal, or other applicable laws. You may ask questions about the nature of this therapeutic relationship at any point in the duration of this relationship.

By signing the informed consent, I voluntarily consent to treatment. I have read the above Informed Consent, Office Policies, and Treatment Agreement (a total of 4 pages). I understand them and agree to comply with them.

Client's Printed Name: _____ Signature: _____ Date: _____

HEALTH INSURANCE CLAIM AUTHORIZATION

By signing the Authorization as part of the Informed Consent, I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts payment (Art of the Heart Counseling Services LLC). I authorize payment of medical benefits to the undersigned physician or supplier of services described in the claims (Art of the Heart Counseling Services LLC).

Client's Printed Name: _____ Signature: _____ Date: _____

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